

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9506	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - STATE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2013
NAME OF PROVIDER OR SUPPLIER MT JULIET HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies This Rule is not met as evidenced by: No deficiencies were cited as a result of Complaint Investigation TN00032433 completed on September 6, 2013.	N 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____